Eau Claire City-County
Health Department

720 Second Ave, Eau Claire, WI 54703
www.echealthdepartment.org
P: 715-839-4718
F: 715-838-2643

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____
(Name of Patient) **(Birthdate)**

authorize _____
(Specify individual, agency or organization, including address)

_____

to disclose to: *Family Planning Clinic, Eau Claire City County Health Department, 720 Second Ave. Eau Claire, WI 54703, Fax: 715-838-2643*

(Individual/Agency/Organization)

the following types of information: *health care including: exams, pap reports, lab tests and medication information.*

I want to include the following information that requires special permission by Wisconsin law:

☐ **Family planning** ☐ **Sexually transmitted disease** ☐ **Alcohol and/or drug abuse treatment**
☐ **HIV** ☐ **Mental health treatment** ☐ **Developmental disability treatment**

I understand that this disclosure is being made for the following purposes: *continuity of care*

This authorization for disclosure of information is effective until: *one year*
(Date of expiration of authorization)

I understand that:

- **Information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.**
- **Failure to sign this authorization form does not jeopardize my program participation.**
- **I have the right to revoke this authorization (in writing) at any time except to the extent that the Health Department has already acted on this authorization. I may arrange for this by contacting the Privacy Officer at 715-839-4718.**
- **I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange for this by contacting the Privacy Officer at 715-839-4718.**
- **If I agree to sign this authorization (which I am not required to do) I must be given a signed copy of the form.**

Dated: _____ _____
(Signature of Patient)

or
Dated: _____ _____
(Signature of Person Authorized by the Patient. This means the parent, guardian or legal custodian of a minor patient.)

THIS FORM DRAFTED BY EAU CLAIRE COUNTY CORPORATION COUNSEL IN CONFORMITY WITH SECTION 146.81(2) AND 51.30, WIS. STATS. AND 45 CFR PART 164.508, EFFECTIVE APRIL 14, 2003.

White Copy: Disclosing Organization Yellow Copy: Recipient Organization Pink Copy: Client